COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

ADULTS (AGES 26-59)
FULL SERVICE PARTNERSHIP
REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

***Insufficient details may delay referral process**

DMH IS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **UNKNOWN**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **MEDICARE** ☐ **PRIVATE** ☐ **HWLA** ☐ **NONE**

BENEFITS: ☐ **GR RECIPIENT** ☐ **V.A.** ☐ **SSI** ☐ **SSDI** ☐ **OTHER INCOME**

☐ **CLIENT SERVED IN THE MILITARY**

PRIMARY CONTACT: _____ **PHONE:** ( ) _____

CONSERVATOR ? ☐ **YES** ☐ **NO** **NAME:** _____ **PHONE:** ( ) _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ Probation ☐ APS ☐ GR/DPSS ☐ Parole: ☐ Revocable* ☐ Non-Recovable

If Individual was referred to any other programs, please identify: _____

Client is aware that an FSP referral has been made on his/her behalf.

* Client is not eligible for services

FOCAL POPULATION

Individual's Name: _____

DMH IS#: _____

CHECK APPROPRIATE **REASON(S) FOR REFERRAL:**

Indicate FSP focal population:	# Days during last 12 months	# Episodes in last 12 months
☐ Homeless		
☐ Chronically Homeless (HUD Standards)*		
☐ Jail		
☐ INSTITUTION TYPE (mark all that apply):		
Acute/Long Term Psychiatric Facilities _____ NAME OF INSTITUTION		
☐ Institution for Mental Disease (IMD)		
☐ State Hospital		
☐ Psychiatric Emergency Services		
☐ Urgent Care Center		
☐ County Hospital		
☐ Fee For Service Hospital		

☐ Living with family members without whose support the individual should be at Imminent Risk of Homelessness, Jail or institutionalization. Specify _____

Document Any Pertinent Outreach Information Regarding Client Here: (Ex. Client is Difficult to Engage, Client Prefers Female Staff, Language Barriers etc.)

*Chronic Homeless HUD: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has had 4 episodes of homelessness in the past three years.

LEVEL OF SERVICE

Individual's Name: _____

DMH IS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ FCCS ☐ Outpatient ☐ PEI ☐ Other: _____
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatrica Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)
- ☐ Other _____

Provide Detail for Any Checked Items:

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area:

SA 1: Angela Coleman	(661) 537-2937	SA 4: Phyllis Moore Hayes	(213) 680-3225	SA 7: Jessica Ahearn	(213) 380-2971
SA 2: Darrell Scholte	(818) 347-8736	SA 5: Maureen Cyr	(310) 313-0813	SA 8: Lisa Powell	(562) 256-1603
SA 3: Eugene Marquez	(626) 471-3572	SA 6: Perla Cabrera	(213) 351-7747	SA 8: Jenny Nguyen	(562) 256-1603

DISPOSITION

Individual's Name: _____

DMH IS#: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: (____) _____

Service Area: _____ Supervisorial District: _____ Fax: (____) _____

Impact Unit Representative: _____ **Date:** _____

(Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area)

TO BE COMPLETED BY FSP AGENCY

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL**

☐ **AGENCY DECLINES TO ENROLL, BUT INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP SERVICES** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES *AND* NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

PREVIOUS FSP ENROLLMENT WITHIN 365 DAYS ☐ **YES** ☐ **NO** **AGENCY** _____

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ (Date) by _____ (Impact Unit Representative)